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A Comparison Between Afro-American and White College Student's Attitudes Toward Suicide

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(TITLE)

BY

Christina M. Mentes

THESIS

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Abstract

The rate of suicide in the United States has increased considerably in recent years making research of suicidal behaviors an important avenue of study. Yet the rate of increase has been inconsistent across demographic variables such as gender, age, and ethnicity, making it difficult to determine risk factors and predictors of suicidal behavior. Previous studies have conflicting results as to whether or not it is possible to determine risk factors by measuring attitudes towards suicide, and whether or not certain demographic variables correlate with attitudes toward suicidal behavior. This study investigates attitudes toward suicidal behavior and demographic variables in order to help clarify research.

One-hundred-and-forty-six college students, ages 17 to 45 enrolled in introductory psychology or sociology courses or involved in Afro American minority groups at Eastern Illinois University and Middle Tennessee State University completed The Suicide Attitude Vignette Experience as modified by Lester, Guerriero, and Watcher (1991), a demographic questionnaire developed for this study, and four questions relating to exposure to suicide.

Results indicate that when an individual is not active in their religion and they view suicide as rational, they will tend to view suicide as appropriate. Results also indicate that when

an individual is white, reports being active in their religion, and views suicide as appropriate they will tend to view suicide as rational. In addition religious activity and gender alone were not significantly related to either subscale, nor were any significant correlations found between the cumulative exposure scores and either subscale of the SAVE. Limitations and implications of these findings are discussed.

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Introduction

Adolescent suicide has dramatically increased in the United States in recent years, yet, across gender, age, and ethnic lines, the rate of increase has not been consistent. For example, Hendin (1995), reports that from 1955 to 1980, the percentage of women age 15-24 who commit suicide has doubled from 2 to 4.3 per 100,000, but the percentage of men in this age range who commit suicide has tripled from 6.3 to 20.2/ 100,000. According to Maris (1985, as cited by Eskin, 1992) suicide is the second largest cause of death in adolescents in the United States. Lester (1993) reports suicide in the third leading cause of death for persons under the age of 24. Even preadolescent suicide rates are on the increase with suicide being the seventh largest cause of death amongst 5 to 14 year olds (Butler, Novy, Kagan, & Gates, 1994). California Vital Statistics Section and the U.S. Public Health Service in 1992 reports a 15% increase in suicide from 1970 to 1990 in all states except California (Males, 1994). According to the National Center for Health Statistics (1992), New Mexico, Alaska, and Nevada report the highest rates of adolescent and overall suicide rates. Finally, Kirk (1993), reports Hispanic adolescent's have a higher rate of suicide than white adolescents, other reports indicate that the overall white suicide rate is about double that of blacks. (Earl & Akers, 1993). Yet even though the rate of black adolescent suicide has been consistently lower than that of white adolescents, the

rate of suicide among black adolescents has almost tripled between 1960 and late 1980 (Earls & Jemison, 1986; National Center for Health Statistics, 1989).

Due to the tremendous rise in suicides in the past two decades, despite a lack of consistency in the increase and rate of suicide across demographic variables, the need for further research on suicide across cultures and gender is evident. This study will focus on adolescents and young college students. This is due to the fact that suicide is the second and third leading cause of death respectively for these two age groups (Maris, 1985; Lester, 1993). For the purpose of this report the term 'young adults' will encompass these two age groups.

History

Suicide, per se, is not a new problem to society, but adolescent suicide is on the rise. According to Berman and Jobes (1991) suicide rates peaked around 1915, 1930, and again in our own time. Adolescent suicides followed this pattern up until the mid 60's when, while all-age suicide remained fairly constant, adolescent suicides jumped from about 7 per 100,000 to almost 13 per 100,000. Suddenly the percentage of adolescents who committed suicide in comparison to the percentage of the general population that committed suicide had increased dramatically. In 1978, the percentage of adolescents committing suicide reached an all time peak and exceeded the percentage of the total population that committed suicide (Berman & Jobes, 1991; Rosenberg, Smith, Davidson, & Cohn, 1987).

Adolescence is not the only factor that seems to be related to suicide rates. As noted earlier, rates among different ethnic groups and genders have remained inconsistent. Native American males are reported to have the highest suicide rate among minority groups (Kirk, 1993). McIntosh (1984) reports a suicide rate of 71 per 100,000 for Native American's between 15 and 23. Black adolescents have historically had a lower rate of suicide than their white counterparts, yet the rate of black male adolescent suicides has tripled between 1960 and the late 1980's. Overall suicide rates of whites are nearly double that of blacks. (Early and Akers, 1993). Even black females, who have had the lowest suicide rate of any ethnic group, showed a 33% increase in suicide rates over the past 40 years (Baker, 1989). Little information has been documented on Hispanic Americans, although their adolescent suicide rates have been reported to be proportionately higher than white adolescents (Smith, Mercy, & Rosenberg, 1989). In summary, in 1988 white males had the highest suicide rate averaging about 18 per 100,000, followed by non-white males averaging about 10 per 100,000. White and non-white females have lower rates of suicide with white females averaging close to 4 per 100,00 and nonwhite females averaging around 3 per 100,000. (National Center for Health Statistics, 1992).

Therefore, while suicide, especially adolescent suicide, is not a new problem in any culture, it continues to be of grave importance to today's society.

Literature Review

The reason why young adults kill themselves is still a much debated area of literature. Across studies, the findings of predictors of suicide continue to remain inconsistent. Psychological, behavior, cognitive and social causes have been explored. As reported by Butler, Novv, Kagan, and Gates (1994) psychological factors seen in suicidal persons include depression, anger, anxiety, and hopelessness. Cognitive factors include thinking styles and inflexibility of thought. Behavioral manifestations in young adults include rebellious behavior, changes in grades, changes in friends, a decline in attendance to school, self destructive acts, impulsivity, and substance abuse. Lester and Bean (1991) divided causes into three components: intrapsychic problems, interpersonal conflict, and societal pressures. Incorporated in these clusters are mental illness, arguments with a lover or spouse, and oppression in society. In 1993, Lester identified different childhood experience that may influence suicidal behaviors such as physical and sexual abuse, childhood loss, and disturbed family relationships. Although all of these reasons seem to be applicable, they do not give researchers a specific pattern to look for to determine those at risk.

Another factor that has been researched is mental health. Mental illness, especially depression, has long been associated with suicidal behaviors. Hendin (1995) makes the distinction between depressed patients who are suicidal and those who are

not. He reports Aaron Beck and his colleges at the University of Pennsylvania found that the degree of depression was not a risk factor, but the degree of hopelessness about the future was. Along with the hopelessness, he reports that anxiety is an even stronger predictor of short term risk than hopelessness. He also includes factors such as the 'inability to maintain or envision any human connections of significance' and unresolved family conflicts. Of interest is the discovery by Marie Asberg and her colleges at the Karolinska Institute in the 1970's that patients who attempted or committed suicide had low cerebrospinal fluid levels of metabolite 5-hydroxyindoleacetic acid (5-HIAA). Low levels of this chemical are also found in violent criminals, murderers, and others with poor impulse control.

Other researchers have attempted to explore the demographic factors that correlate with suicidal risks. Researchers have looked at age, gender, SES, and regional demographics. And while these variables are correlated with suicide, no specific pattern has been found that is associated with adolescents who are at higher risk. (Butler, et al., 1994)

Some researchers take another approach and explore attitudes towards suicide. Stein, Witztum, Brom, DeNour, & Elizur, (1992) included gender, ethnic background, SES, religious affiliation, nonintact families, and exposure to suicidal behaviors in significant others into their study. They found that gender, religious involvement and exposure to suicide were all significantly associated with attitudes toward suicide. The

expectation was that adolescents with increased suicide risk would demonstrate a more negative or non accepting attitude towards suicide providing a defense against their suicidal impulses. To the contrary it was found that adolescents with a more positive or accepting attitude towards suicide were associated with an increased risk of suicidal tendencies.

If attitudes towards suicidal behavior can help us determine risk factors and the general acceptability of suicide, perhaps we can use this information to both intervene and educate young adults before suicidal actions occur. Norton, Durlak & Richards (1989) found that high school students attitudes towards suicide did not correlate with knowledge about suicide, but did correlate with knowledge about suicide interventions. Subjects with more negative attitudes towards other adolescent's suicide scored lower on a scale that assessed ability to respond to a suicidal person. While other researchers such as Stein et al.,(1992), found that negative attitudes towards suicide correlated with less suicide risk for the individual, Norton et al.,(1989), voices concern that a negative attitude towards peer suicide could result in less desire to learn intervention skills and an increase in the suicidal individual's feelings of isolation from friends. These confounding theories further promote the necessity of determining what factors influence attitudes towards suicidal behavior.

Many of the factors that correlate with suicide have been found to correlate with attitudes towards suicide. These include

religion (Domino & Miller, 1992; Stack & Wasserman, 1992; Stein, 1995) , exposure to suicide (McDonald & Range, 1990; Gibson & Range, 1991; Norton, Durlak & Richards, 1989), race and culture (Ingram & Ellis, 1992; Domino & Perrone, 1993; Eskin, 1992; Males, 1994), and other demographic factors such as life ownership orientation, geographic location, and socioeconomic status.(Ross & Kaplan, 1993; Antoon & Domino, 1993; Stein et. al., 1992).

The thought that certain religions classify suicide as an immoral act has been thought to reduce suicide and promote negative attitudes within groups that are highly religious. Other aspects of the church may also effect attitudes about suicide. For example, Stack and Wasserman (1992) show how networking within different religious organizations correlates with reduced suicidal ideology with in the congregation. Thus the increased social support may help reduce suicidal ideology and may effect attitudes towards suicidal individuals.

Contagion and exposure to suicide are major, albeit controversial areas of the literature. Contagion is defined by Berman (1991) as:

> When suicidal events occur close together in space and time or when suicidal events share characteristics (e.g., a similarity of method), beyond what would be normally expected in a given community, such connections suggest an influence among events or triggering by one or more of the preceding events. p.102.

The Center for Disease Control classifies such an event as a 'cluster' if there are three or more events in the series. (Berman & Jobes, 1991). Contagion and clustering are controversial issues due to the difficulty in determining if the person who commits suicide was actually exposed to the media covering the story. (Biblarz, Noonan, Pilgram, and Baldree, 1991) Previous research has found exposure to suicide has invariably been associated with increased suicide risk. (Stein et al., 1992; Stein et al., 1989; Shaffer et al., 1988). Berman and Jobes, (1991), do not agree that this is conclusively researched. They suggest that the research is inconclusive as to the effect media has on subsequent suicides. Berman and Jobes do acknowledge that the effects have been documented in cases of imitation and identification with the suicidal person. In other words, if the suicidal person was an acquaintance or respected individual such as a celebrity, the effects of those suicides have been documented. Exposure to suicide has also been correlated with attitudes towards suicide. Stein et. al. (1992) reports that subjects exposed to suicide showed a significantly more accepting attitude towards suicide. With this information, we can not rule out contagion as a possible factor in the formation of attitudes towards suicide. It can not be said that in some cases, some suicides do not influence perspective suicidal behavior. How the increase in young adults committing suicide, those involving contagion and those not, influences attitudes of their peers is not dealt with extensively in research.

Race, culture, and geographic location have also been associated with attitudes toward suicide. Statistics show that Non-Whites experience 1/3 the suicide rate of whites. (Males, 1994) Ingram & Ellis (1992) report that Blacks are less likely to approve of suicide when one has a terminal illness than Whites. They also found that approval of suicide was lowest in the southern regions of the United States. Several other studies have shown a relationship between attitudes towards suicide and geographic location. Leenaars and Domino (1993) compared the difference of attitudes towards suicide in Winsor and Los Angeles, Domino and Perrone (1993) studied attitudes towards suicide in Italian and U.S. physicians, and Domino and Leenaars studied attitudes toward suicide in Canadian and U.S. college students. All three studies found significant differences in attitudes towards suicide between subjects from different regions. Certain cultures in history actually expected individuals to commit suicide. For example, when a chief died in the Fiji Islands, his surviving wives were expected to kill themselves believing the first to die would be the chief's favorite in the spirit world. (Ingram & Ellis, 1992).

Other demographic factors influencing attitudes towards suicide include gender and education. In a review of the literature on suicidal behavior, Ingram and Ellis, (1992), report that men are more likely to have negative attitudes towards suicide than are women. Stillion, White, Edwards, & McDowell,(1989) disagree, reporting that young males agreed more

with suicide attempts than did any other group consisting of young females and older males and females. Ingram and Ellis, (1992) also determined that people with more education were more accepting of euthanasia than those with a lower education.

As can be seen by the inconclusive results from previous studies, further research on attitudes towards suicide behavior is warranted. To that end, the study reported here was undertaken to help clarify the relationship between attitudes towards suicide and certain personal variables including race, gender, previous exposure to suicide, and religious activity.

Methods

Participants. One-hundred-and-forty-six Black and white college students, ages 17 to 45 (M = 21.4) enrolled in introductory psychology or sociology courses or involved in Afro American minority groups at Eastern Illinois University (n = 61, 41.8%) and Middle Tennessee State University (n = 85, 58.2%) voluntarily participated in this study; 64% were female and 35% were male; 47% were Black and 53% white.

Materials. The Suicide Attitude Vignette Experience, SAVE, as modified by Lester, Guerriero, and Watcher (1991), was used to assess attitudes towards suicide. This modified version was chosen due to the vignettes' all reflecting completed suicides as well as the clarity of the rating scale. The subscales of the SAVE (Inappropriate/ Appropriate and Irrational/Rational) were scored in a positive direction, i.e. higher scores indicate that suicide was viewed as appropriate and rational.

Age, gender, race, and activity in one's religion were assessed using a questionnaire (see Appendix A). Religious activity was assessed with one item which asked individuals to indicate "whether you are an active or nonactive member" (of your religion) and scored 0, 1 = active. Seventy-nine students (57%) indicated they were active in their religion.

In addition, the questionnaire contained four questions concerning previous exposure to suicide: 1) Do you know anyone who has completed suicide? 2) Do you know anyone who has attempted suicide? 3) Have you watched television programs or

movies with suicidal themes in the past? 4) Have you been educated on suicide and/or suicide interventions? A cumulative exposure score was calculated as the number of situations individuals had experienced. All the participants (100%) indicated that they had some sort of exposure to suicide. Ninety-five percent reported having watched television programs of movies of suicide and 72% had received education on suicide and/or suicide interventions; 67% knew someone who had attempted suicide while 43% actually knew someone who had completed suicide. Fully 30% of participants reported having experienced all four types of exposure.

Procedure. Prior to participation, individuals signed an informed consent form which explained that participation in the study was voluntary and all information provided would be kept confidential (see Appendix A); they were also informed that they could withdraw from the study at any time. After the consent forms were completed, participants received a copy of the SAVE to complete along with the questionnaire described above.

Upon completion of the questionnaire, participants were debriefed as to the purpose of the study. Participants were also provided with the phone number of local agencies that could provide more information about suicide and suicide crisis hotlines.

Results

The analyses was conducted in two staged: a series of analysis of variance followed by a series of correlations. The initial analysis examined the possible effects of university using 2-way ANOVAs (university x race) of the two suicide attitude scales. There were no significant main effects or interactions for university ($p > .05$); therefore, university was excluded from all further analyses.

To determine the possible effects of race and gender, the scores on the SAVE subscales were examined using 2-way analyses of variance. No significant main effects of interaction were found for the Appropriateness Subscale (all p's $> .05$). For the Rationality subscale, a significant main effect for race revealed that whites ($M = 16.06$) viewed suicidal behavior as more rational than did blacks ($M = 12.46$), $F(1,133) = 12.70$, $p = .001$.

Correlations of the subscales of the SAVE indicate that judgements of the appropriateness and rationality of suicide are moderately inter-related, $r = 76$, $p = .001$. Neither subscale was significantly related to religious activity ($p > .05$) nor were any significant correlations found between the cumulative exposure scores and either subscale of the SAVE.

To determine if any combination of variables would serve as predictors of the tendency to judge suicide as appropriate and rational, multiple regression analyses were performed with each measure of attitude toward suicide (Inappropriate/ Appropriate and Irrational/ Rational) as the criterion. For each analyses,

several variables served as the potential predictors: Race, sex, age, prior exposure to suicide, activity in religion, and the other suicide attitude subscale; That is, rationality was entered as a predictor of appropriateness and appropriateness served as a predictor for rationality.

Attitude toward the appropriateness of suicide was predicted by attitude concerning the rationality of suicide and activity in one's religion (see Table 1a); this equation accounts for 58% of the variance. The signs for the weightings (Beta) indicate suicide was viewed as appropriate when it was viewed as rational, and the individual was not active in their religion. Attitude toward the rationality of suicide was predicted by attitude concerning it's appropriateness, race, and activity in ones religion (see Table 1b); this equation accounts for 61.5% of the variance. The signs for the weightings (Beta) indicate suicide was viewed as rational when it is viewed as appropriate, the individual is white, and active in their religion.

Because race was entered into the equation for the Rationality subscale, that analysis was repeated separately for each race. For Blacks, only the Appropriateness subscale was predictive, R = .887. The analysis for whites (see Table 2) also included the Appropriateness subscale, but also religious activity; this combination accounts for 47% of the variance.

Discussion

Does race, religious activity, exposure to suicide, or gender effect a person's attitude toward suicidal behavior? These and other questions served as a starting point in this study related to suicide. Previous studies have shown varying and contradicting results. This present study helped to support some past findings, while yielding certain other interesting results.

Using the Suicide Attitude Vignette Experience, as modified by Lester et. al. (1991), this study measured tendencies of the subject to judge suicide behavior as irrational/rational and inappropriate/appropriate. As in Lester et al's study, (1991), it was found that there was no significant association between gender and the rating of suicide behavior as irrational or inappropriate. Another finding also supports the strong interrelatedness of the Rationality and Appropriateness subscales found by Lester et al. (1991).

An area of interest that has not been thoroughly researched is the difference in attitude towards suicide behavior in blacks and whites. Ingram and Ellis, (1992) note that blacks are less likely to approve of suicide when one has a terminal illness than Whites and Early and Akers (1993) discuss possible reasons for lower suicide rates amongst blacks. It might be concluded from this that blacks would have a more negative attitude towards suicide behavior than whites. Indeed, in the present study it was found that blacks view suicidal behavior as more irrational

than whites. One possible explanation is that when looking at the definition of rationality, one thinks of an act that is planned out and justified and involves a realistic assessment of a situation. Since there was no significant difference in black and white scores of appropriateness of suicide, one could conclude that while blacks may be able to agree with the appropriateness behind suicidal behavior, ultimately they may not be able to accept that suicide is a rational choice of action.

When examining the findings concerning religious activity and attitudes towards suicide, interesting results appear. Previous research has long since documented a positive correlation of religious affiliation and negative attitudes towards suicide behavior (Best & Kirk, 1982; Stein, Witztum, Brom, DeNour, & Elizur, 1992; Domino & Miller, 1992). This study found that persons who view suicidal behavior as more rational and who report not being religiously active tend to view suicide as significantly more appropriate. In other words, persons who report being religiously active and who see suicide behavior as more irrational will tend to view suicide behavior as more inappropriate. What is inconsistent with previous research is the finding that persons who view suicidal behavior as more appropriate, who report being religiously active, and who are white tend to view suicide as significantly more rational. It could be that persons who are white and more religiously active believe that both the thought process behind a suicide and actual act of suicide are the correct answers to a difficult situation.

This does not seem likely, nor does it concur with common religious beliefs. So how can these findings be explained?

First, it is interesting to note the high percentage of persons who report knowing someone who has attempted a suicide (67%) or knowing someone who has completed a suicide (43%). Perhaps knowing someone who has attempted or completed a suicide would cause one to become more accepting of suicide behavior in order to maintain positive feelings towards the person. It would be interesting to correlate attitudes of persons who report being religiously active with attitudes of persons who report knowing someone who has completed or attempted a suicide.

Another possibility might appear if we took a closer look at the analysis and compared specific religions or churches with persons who found suicide behavior to be more appropriate. Could it be that a specific Christian denomination or church has less rigid beliefs on the value of life? It seems more plausible given certain contemporary nontraditional modes of thinking that occur with certain subgroups. Most recently the California mass suicide (1997), serves as an example of how scripture can be used to misinform a group of people.

Of course, there are less complicated explanations to explain the findings. The participants were all college students attending Midwestern and Southern midsize state Universities. Attitudes of a random sample of such a middle class college population may simply reflect their tendency to judge suicide as rational or appropriate.

While this study has provided some useful information, it continues to remain unclear as to the exact relationship between race and attitudes towards suicide behavior. It would be important to replicate this study, preferably with a larger and broader sample. Further more, investigations focusing on geographic location, specific exposures, religious affiliation, and individual questions on the SAVE would help to further shed light on attitudes towards suicidal behavior.

Table 1

Predicting Attitudes Toward Suicide

(a)

Appropriateness of Suicide

Predictor	R	R^2	Change in R^2	Beta
Suicide is Rational	.7508	.5637	------	.753
Active in Religion[a]	.7625	.5815	.0177	-.133

(b)

Rationality of Suicide

Predictor	R	R^2	Change in R^2	Beta
Suicide is Appropriate	.7508	.5637	----	.732
Race[b]	-.7742	.5994	.0356	-.202
Active in Religion[a]	.7839	.6146	.0152	.125

[a]Coded no = 0, yes = 1

[b]Coded White = 1, Black = 2

Table 2

Predicting Attitudes of Whites Toward the Rationality of Suicide

Predictor	R	R^2	Change in R^2	Beta
Suicide is Appropriate	.6485	.4206	-----	.670
Active in Religion[a]	.6872	.4723	.0516	.228

[a]Coded no = 0, yes = 1

References

Ackerman, G.L. (1993). A congressional view of youth suicide. Special Issue: Adolescence. American Psychologist, 48(2), 183-184.

Antoon, A., Domino, G. (1993). A comparison of community attitudes towards suicide in Windsor and Los Angeles. Canadian Journal of Behavior Science, 25(2), 253-266.

Baker, F. (1989). Black Youth Suicide. In Report of the Secretary's Task force on Youth Suicide: Vol 3. Prevention and intervention in youth suicide (DHHS Publication No. ADM 89-1623). Washington , DC: U.S. Government Printing Office.

Berman, A., Jobes, D. (1991). Adolescent Suicide. American Psychological Association, Washington DC.

Biblarz, A., Brown, R. M., Biblarz, D. N., Pilgrim, M., et al. (1991). Media influence on attitudes toward suicide. Suicide and Life Threatening Behavior, 21(4), 374-384.

Butler, J. W., Novv, D., Kagan, N., Gates, G. (1994). An investigation of differences in attitudes between suicidal and nonsuicidal student ideators. Adolescence, 29(115), 623-638.

Domino, G., Miller, K. (1992). Religiosity and attitudes toward suicide. Omega Journal of Death and Dying, 25(4), 271-282.

Domino, G., Leenaars, A. (1989). Attitudes toward suicide: A comparison of Canadian and U.S. college students. Suicide and Life Threatening Behavior, 19(2), 160-172.

Domino, G., Leenaars, A. (1993). Attitudes toward suicide: Italian and United States Physicians. Omega, 27(3)195-206.

Domino, G., Takahashi, Y. (1991). Attitudes toward suicide in Japanese and American medical students. Suicide and Life Threatening Behavior, 21(4), 345-359.

Earls, F., Jemison, A. (1986). Suicidal behavior in American Blacks. In G. Klerman (Ed.), Suicide and depression among adolescents and young adults. Washington, DC: American Psychiatric Press.

Early, K., Akers, R., (1993). "It's a white thing": an exploration of beliefs about suicide in the african-american community. Deviant Behavior: An Interdisciplinary Journal,14, 277-296.

Eskin, M. (1992). Opinions about and reactions to suicide, and the social acceptance of a suicidal classmate among Turkish high school students. International Journal of Social Psychiatry, 38(4), 280-286.

Gibson, J.P., Range, L. M. (1991). Are written reports of suicide and seeking help contagious? High schoolers' perceptions. Journal of Applied Social Psychology, 21(18), 1517-1523.

Hendin, H., M.D. (1995). Suicide in America. W.W. Norton and Company, New York.

Ingram, E., Ellis, J.B. (1992). Attitudes toward suicidal behavior: A review of the literature. Death Studies, 16(1), 31-43.

Kirk, W.G. (1993). Adolescent Suicide. Research Press, Illinois.

Lester, D. (1993). The Cruelest Death: The Enigma of Adolescent Suicide. The Charles Press, Philadelphia.

Lester, D., Bean, J. (1992). Attribution of causes to suicide. Journal of Social Psychology, 132(5), 679-680.

Lester, D., Guerriero, J., Watcher, S. (1991). The Suicide Attitude Vignette Experience (SAVE): A search for sexual stereotypes in the perception of suicidal behavior. Death Studies, 15, 435-441.

Lester, D., Hadley, R. A., Lucas, W. A. (1990). Personality and a pro-death attitude. Personality and Individual Differences, 11(11), 1183-1185.

Lester, D. (1990-91). Attitudes toward the survivors of suicide as a function of the motive for suicide. Omega Journal of Death and Dying, 22(3), 215-218.

Males, M. (1994). California's suicide decline, 1970-1990. Suicide and Life Threatening Behavior, 24(1), 24-37.

Marra, R., Orru, M. (1991). Social images of suicide. British Journal of Sociology, 42(2), 273-288.

McDonald, D. H., Range, L. M. (1990). Do written reports of suicide induce high-school students to believe that suicidal contagion will occur? Journal of Applied Social Psychology, 20(13, Pt 1), 1093-1102.

National Center for Health Statistics. (1989). Monthly vital statistics report, 37(13). Washington DC: U.S. Government Printing Office.

National Center for Health Statistics. (1992). Vital statistics of the United States: Vol. 2. Morality-Part A. Washington, DC: U.S. Government Printing Office.

Norton, E. M., Durlak, J. A., Richards, M. H. (1989). Peer knowledge of and reactions to adolescent suicide. Journal of Youth and Adolescence, 18(5), 427-437.

Rosenburg, M., Smith, J., Davidson, L., Conn, J. (1987). The emergence of youth suicide: An epidemiologic analysis and public health perspective. Annual Reviews of Public Health, 8, 417-440.

Ross, L., Kaplan, K. (1993). Life ownership orientation and attitudes towards abortion, suicide, doctor-assisted suicide, and capital punishment. Omega, 28(1), 17-30.

Smith, J.C., Mercy, J., Rosenberg, M. (1989). Hispanic suicide in the Southwest, 1980-1982. In Report of the Secretary's Task force on Youth Suicide: Vol 3. Prevention and intervention in youth suicide (DHHS Publication No. ADM 89-1623). Washington , DC: U.S. Government Printing Office.

Stack, S., Wasserman, I. (1992). The effect of religion on suicide ideology: An analysis of the networks perspective. Journal for the Scientific Study of Religion, 31(4), 457-466.

Stein, D., Witztum, E., Brom, D., De-Nour, A. K., et al. (1992). The association between adolescents' attitudes toward suicide and their psychosocial background and suicidal tendencies. Adolescence, 27(108), 949-959.

Stillion, J., McDowell, E., Shamblin, J. (1984). The Suicide Attitude Vignette Experience: A Method for Measuring Adolescent Attitudes Toward Suicide. Death Education, 8, 65-79.

Stillion, J., White, H., Edwards, P., McDowell, E. (1989). Ageism and sexism in suicidal attitudes. Death Studies, 13, 247-261.

Appendix A

Please complete the following:

Age _____ Gender M F

Race: White (non hispanic)

Black

Hispanic

Native American

Other _____

Religious Affiliation (for example: Catholic, Baptist, Jewish, etc.): Note whether you are an active or nonactive member.

Affiliation: _____

ACTIVE NONACTIVE

Please answer the following by circling YES or NO.

1) Do you know anyone who has completed suicide?

YES NO

2) Do you know anyone who has attempted suicide?

YES NO

3) Have you watched television programs or movies with suicidal themes in the past?

YES NO

4) Have you been educated on suicide and/or suicide interventions?

YES NO

Appendix B

I understand that participating in this study is voluntary and I may withdraw at any time. Any information provided will remain strictly confidential. You will be provided with two questionnaires. Do not write your name on either questionnaire. One will ask for demographic information and the other will have more specific questions concerning suicide. Upon completion of both questionnaires, someone will explain to you the purpose of this study and will answer any questions you might have.

I have read the above statement and agree to participate in this study.

Signature Date